HIPAA FOR CORRECTIONS & LAW ENFORCMENT

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This is the twenty-first article from the Supreme Court of Ohio Advisory Committee on Mentally Ill in the courts about effectively dealing with offenders with mental illness. This article focuses on the Health Insurance Portability and Accountability Act and its impact on corrections and law enforcement.

INTRODUCTION

Since April 14, 2003, anyone who has had a prescription filled or received a medical service from a hospital or physician should have received a "*NOTICE OF PRIVACY PRACTICES*"[1] and may recognize the term "*HIPAA*."[2] Title I of HIPAA was enacted for the purpose of protecting health insurance coverage for workers and their families when changing or losing their jobs, generally eliminating what many workers who have been in the workforce may recall as the problem of a new employer's group health benefit excluding insurance coverage for pre-existing conditions for periods such as one year. This practice was largely eliminated by the passage of this act. Although most everyone immediately felt the benefit of this law the Administrative Simplification provisions of HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. The intent of adopting these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care and to facilitate the ability of individual health systems to communicate in common electronic languages with payors such as Centers for Medicare and Medicaid Services. The act required that in the event Congress failed to enact these security and privacy statutes, the federal Department of Health and Human Services was required to enact regulatory provisions. The administrative simplification and privacy provisions have been in the making for the past four years with the final privacy provisions affecting certain small health care insurers effective April 14, 2004. Other administrative simplification standards are still being enacted with the most recent standard unique health identifier regulations for providers, was just published in the Federal Register on January 23, 2004, with a compliance date of May 23, 2005. HIPAA's Administrative Simplification are regulations requiring that uniform privacy and security standards concerning the protection of health information be adopted to facilitate the electronic transmission of health information, primarily to enhance the

[1] 45 CFR §164.520
[2] Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191 HR 3103,424 pp.)

processing of insurance claims for both Medicare and state medical assistance programs and other third party insurance carriers.

The focus of this article addresses one small provision of the HIPAA privacy regulations affecting law enforcement and corrections in the area of sharing behavioral health[3] information. The scope and complexity of the nearly 700 pages of privacy and administrative simplification regulations cannot be covered in the scope of one short article.

Many myths continue to exist about HIPAA requirements. Institutional health care providers[4], such as hospitals and community health care facilities have had just enough education about the requirements to make them apprehensive about potential violations.[5] Provider anxiety due largely to statutory civil monetary penalties is singly the greatest impediment in sharing the health care data needed by law enforcement and corrections personnel to effectively intervene in inmates and detainee's mental illness or substance abuse disorders.

Although individual state laws may require patient consent, for the release of records HIPAA itself, does not require or even promote the practice of obtaining a patient's authorization for providers to share individually identifiable health information[6] and protected health information (PHI)[7] with other providers regarding the treatment of a mutual patient.

HHS[8] believes patients have a reasonable expectation that professionals involved in their care can and will share relevant information about them as needed. HIPAA imposes no restriction in this area and specifically permits the exchange of information for purposes of treatment, payment and health care operations, otherwise known as "TPO." Unfortunately, mistakenly blaming a cumbersome and chaotic health care system the standardization of health care

[3] Alcohol and Drug abuse and dependence and mental health issues are collectively referred to by treatment professionals as Behavioral Health.

[4] Providers including both individual health care practitioners, hospitals, behavioral health care organizations are collectively referred to in the regulations as "covered entities."

[5] The regulations are clear that HIPAA violations are not to be used as a basis for private claims against a provider. The sole remedy for a HIPAA violation is through the Office of Civil Rights.

[6] (45 CFR S 160.103) Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

[7] (45 CFR S 160.103) Protected health information means individually identifiable health information: (1) Except as provided in paragraph (2) of this definition[certain educational and employment records], that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

[8] Department of Health and Human Services

claims submission and the attendant regulatory protection needed in an electronic age, has given HIPAA a bad name. In reality the complicated mix of state and other federal regulations and their relationship to HIPAA is the real source of provider confusion. On the other hand, hospitals must take reasonable steps to ensure that PHI is only released when appropriate. Each healthcare organization must clarify its own policy and explain the reasoning behind it. At the same time, the organization can review its policy and procedure to find simpler, less burdensome ways to achieve the same goal without requiring formal authorization.

HIPAA regulations do not prevent the disclosure of protected health information (PHI) from providers or covered entities to jails/correctional facilities/law enforcement. Any PHI sharing restrictions are due to more stringent state law, administrative regulations, and federal Drug and Alcohol regulations. The HIPAA privacy regulation are merely a federalized floor of protection for patient's health care information and records in the absence of state regulation. HIPAA specifically includes law enforcement and correctional facilities as entities with whom detainee and inmate PHI can be released from health care providers without the written consent of the patient.

Ohio, however, in the context of sharing a patient's behavioral health information, already has law governing the release of confidential mental health and substance abuse information. To facilitate the flow of behavioral health information to correctional facilities without patient authorization, would require Ohio law and administrative regulatory changes. In addition, those patients being treated for a drug/alcohol condition, other federal regulations prevent the disclosure of information without a patient's consent except in cases of emergency.

Some other HIPAA provisions beyond the scope of this article, are the right of patient access to their health information except in very limited circumstances, such as psychological progress notes, patient right to request amendment to their health information and the right for an accounting (with exceptions) of those persons to whom PHI has been released by a provider.

BUSINESS AS USUAL

Concerning issues of privacy and record release in the behavioral health care, it is business as usual. In states such as Ohio with existing privacy regulations, the HIPAA provisions are irrelevant. HIPAA only serves to confuse providers medical records technicians about current requirements governing record release. Any law enforcement or corrections staff attempt to

convince the behavioral health provider that HIPAA specifically permits your access to an inmate's records will be met with resistance or disagreement from well intentioned providers. Except to modify some forms and procedures the privacy provisions of the federal HIPAA regulations made little practical difference as to how behavioral health care providers conduct the business of sharing information. In fact, if the federal privacy regulations had preempted or replaced Ohio privacy law, the correct legal conclusion would be that a provider could share without limit health information about their patient with law enforcement and corrections staff. Had this been the case behavioral health patients in Ohio would have been left with far less security and protection of their health information than existed prior to April 14, 2003.[9] This however is not the case!

PREEMPTION.

Ohio privacy laws are not preempted by HIPAA confidentially regulation[10] when the provision of state law, relates to the privacy of individually identifiable health information **AND** is "more stringent"[11] than the federal HIPAA regulation. The regulation as published in the federal register provides some instruction for state courts in balancing HIPAA with state regulations and one could draw the inference that Courts would not be permitted to reduce the protections afforded a patient under the federal privacy regulations.[12]

[9] April 14, 2003, is the date requiring health care providers to be in compliance with the privacy portion of HIPAA.

[10] 45 § 160.203

[11] 45 § 160.202-"more stringent" means, in the context of a comparison of a provision of State law and a standard, requirement, or implementation specification adopted under subpart E of part 164 of this subchapter, [HIPAA] a State law that meets one or more of the following criteria: (1) With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under this subchapter, except if the disclosure is: (i) Required by HSS in determining whether a CE is in compliance with HIPAA regulations; or (ii) To the individual who is the subject of the individually identifiable health information. (2) With respect to the rights of an individual who is the subject of the individually identifiable health information of access to or amendment of individually identifiable health information, permits greater rights of access or amendment, as applicable; provided that, nothing in this subchapter may be construed to preempt any State law to the extent that it authorizes or prohibits disclosure of protected health information about a minor to a parent, guardian, or person acting in loco parentis of such minor. (3) With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and remedies, provides the greater amount of information. (4) With respect to the form or substance of an authorization or consent for use or disclosure of individually identifiable health information, provides requirements that narrow the scope or duration, increase the privacy protections afforded (such as by expanding the criteria for), or reduce the coercive effect of the circumstances surrounding the authorization or consent, as applicable. (5) With respect to record keeping or requirements relating to accounting of disclosures, provides for the retention or reporting of more detailed information or for a longer duration. (6) With respect to any other matter, provides greater privacy protection for the individual who is the subject of the individually identifiable health information.

[12] 65 FR 82462 State courts and other decision-making bodies may choose to examine more closely the circumstances and propriety of such consent and may adopt more protective standards for application in their proceedings. In the judicial setting, as in the legislative and executive settings, states may provide for greater protection of privacy. Additionally, both the Congress and the Secretary have established a general approach to protecting from explicit preemption state laws that are more protective of privacy than the protections set forth in the HIPAA privacy regulation.

HIPAA is not as complex as most behavioral health providers believe it to be. HIPAA permits (does not require) covered entities to use and disclose protected health information for purposes of treatment, payment and health care operations, (TPO) without the specific authorization of the patient, except as may be limited by state law. Thus one provider referring a patient to another provider may provide treatment records. (Except in the case of behavioral health care, where CE's must comply with other state and/or federal confidentiality provisions.

HIPAA IN CORRECTIONAL FACILITIES.[13]

Correctional facilities directly providing health care services are Covered Entities and are required to implement the HIPAA regulations. The initial rule published in the Federal Register Dec. 2000 was not modified in the final regulation August 2002, relative to several exceptions to which "uses and disclosures" of PHI for which an "authorization" is necessary. A covered entity (provider) may choose to disclose without a written patient authorization to correctional institutions[14] and other law enforcement custodial situations.[15]

MORE STRINGENT.

There are numerous Ohio regulations and statutes which would likely be interpreted as being more stringent and thus supersede federal HIPAA privacy regulations. Some examples are O.R.C. § 5122.31 Patient rights in confidential mental health records; privilege statutes governing confidential communications made to physicians, psychologists, counselors, social workers; Client right of confidentiality (OAC 5122-1-02(D)(13)); Patient Care Policies and Record Confidentiality (OAC 3701-84-07(A)(4)); Civil Rights of Drug and Alcohol Patients Confidentiality (O.R.C. Section 3793.14)

In addition the HIPAA privacy regulations were not enacted for the purpose of changing other applicable federal law such as federal Drug & Alcohol Regulation [16] governing the records of

[13] 45 CFR § 164.512(K) Utilization and Disclosure Specialized Government Functions

[14] Correctional Institution [defined in HIPAA as] any penal or correctional facility, jail, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial. (45 CFR § 165.501)

[15] 45 CFR § 164.512 (K)(5) (i-iii)

[16] 42 CFR Part 2

patients receiving treatment services for drugs and alcohol in federally funded facilities[17].

The final privacy rule considers Individually Identifiable Health Information of prisoners and detainees to be protected health information to the extent it meets the definition and is maintained or transmitted by a covered entity.

LAW ENFORCEMENT & CORRECTIONS EXCEPTIONS

HHS has stated in response to public comments in the initial proposed regulation, its agreement that correctional facilities have legitimate needs for use and sharing of individually identifiable health information inmates without authorization. It was for this reason (§ 164.512(k)(5)) that permits a covered entity to disclose protected health information about inmates without individual consent, authorization, or agreement to correctional institutions for specified health care and other custodial purposes. For example, covered entities are permitted to disclose for the purposes of providing health care to the individual who is the inmate, or for the health and safety of other inmates or officials and employees of the facility. In addition, a covered entity may disclose protected health information as necessary for the administration and maintenance of the safety, security, and good order of the institution. See the preamble discussion of the specific requirements at s 164.512(k)(5), as well as discussion of certain limitations on the rights of individuals who are inmates with regard to their protected health information at §§ 164.506, 164.520, 164.524, and 164.528. HHS clarified that covered entities providing services under contract to correctional institutions must treat protected health information about inmates in accordance with this rule and are permitted to use and disclose such information to correctional institutions as allowed under s 164.512(k)(5).[18]

HIPAA expressly carved out exceptions for the use and disclosure of protected health information without inmate or detainee formal consent.[19]

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[17] Federally funded facilities are broadly defined to include those facilities which accept state administered federal funds such as Medicaid.

[18] A Business Associate Agreement is required of those who perform services on behalf of a covered entity who have access to PHI of a patient.

[19] 45 § 164.512 (K)(5) Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required. (i) A covered entity may use or disclose protected health information without the written consent or authorization of the individual as described in §§164.506 and 164.508, respectively, or the opportunity for the individual to agree or object as described in s 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.
(5) Correctional institutions and other law enforcement custodial situations. (i) Permitted disclosures. A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for: (A) The provision of health care to such individuals; (B) The health and safety of such

Although HIPAA regulations permit a covered entity to share protected health information with a corrections facility in those six circumstances identified in 45 § 164.512 (K)(5), it is unlikely that any facility will provide the information without a written consent of the patient because of conflicting more stringent Ohio regulations, thus preempting 45 § 164.512(K)(5). HIPAA does not require a health provider to disclose information except as may be authorized by the patient. It is unlikely that any provider will voluntarily disclose protected health information without the inmate-patient's written authorization. HHS in the final HIPAA regulation eliminated a blanket exemption for health information maintained by correctional facilities and jails by bringing them under the privacy regulations affording inmates privacy protection to prevent the potential for misuse of the information. The final rule considers individually identifiable health information of individuals who are prisoners and detainees to be protected health information to the extent that it meets the definition and is maintained or transmitted by a covered entity. As to former inmates, the final rule considers such persons who are released on parole, probation, supervised release, or are otherwise no longer in custody, to be individuals who are not inmates. Therefore, the permissible disclosure provision at s 164.512(k)(5) does not apply in such cases. Instead, a covered entity must apply privacy protections to the protected health information about former inmates in the same manner and to the same extent that it protects the protected health information of other individuals. In addition, individuals who are former inmates hold the same rights as all other individuals under the rule.

As to individuals in community custody, the final rule considers inmates to be those individuals who are incarcerated in or otherwise confined to a correctional institution. Thus, to the extent that community custody confines an individual to a particular facility, §164.512(k)(5) is applicable.

Also note, nothing in HIPAA prevents a correctional facility or jail, not a covered entity, from providing symptoms and health information about an inmate to a covered entity such as a community mental health center.

SUMMARY

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individual or other inmates; (C) The health and safety of the officers or employees of or others at the correctional institution; (D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another; (E) Law enforcement on the premises of the correctional institution; and (F) The administration and maintenance of the safety, security, and good order of the correctional institution. (ii) Permitted uses. A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed. (iii) No application upon release. For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

A cursory reading of the HIPAA regulation, alone, would appear to facilitate the exchange of an inmate's or detainee's health information between the corrections staff and the treating facility. However due to the preemption provision, Ohio law governing the disclosure of clinical information pertaining to an inmate's mental health or substance abuse evaluation or treatment will fall within the "more stringent" provisions and thus prevent a provider from freely sharing information with the correctional facility without a written waiver executed by the inmate-patient. In reality HIPAA has had no significant impact in the context of the ability of a jail or correctional facility to obtain or a provider to disclose protected behavioral health information.